Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Forteo Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Forteo.

Additional information about Forteo can be found within the MassHealth Drug List at **www.mass.gov/masshealth.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Section I

Forteo 20 mcg SQ once a day

Forteo _____ (Please specify dosing regimen and rationale for this regimen.)

Indication for Forteo (Check one or all that apply.)

☐ Post menopausal osteoporosis (PMO) ☐ Primary/Hypogonadal osteoporosis ☐ Other: _____

Has member had a radiographically confirmed fracture?

☐ Yes. Please provide site of fracture and date of occurence (if known): _____

☐ No.

Date/results of baseline BMD measurements: Please provide baseline T-scores of total hip and lumbar vertebrae (L1-L4).

_____

_____

Date/results of any subsequent BMD measurements: Please provide T-scores of total hip and lumbar vertebrae (L1-L4).

_____

_____

Is member under the care of a rheumatologist or endocrinologist? ☐ Yes ☐ No

Name of rheumatologist or endocrinologist: _____

Date of last visit with rheumatologist or endocrinologist: _____

Please list all supplements and medications currently prescribed for this member.

_____

_____

Please list all non-modifiable risk factors for fracture in this member.

_____

_____

Medication information (cont.)

Section II

Has member tried alendronate (Fosamax) to treat this condition?

☐ Yes. Complete box A. ☐ No. Explain why not. _____

A. Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other: _____

Has member tried risedronate (Actonel) to treat this condition?

☐ Yes. Complete box B. ☐ No. Explain why not. _____

B. Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other: _____

Has member tried raloxifene (Evista) to treat this condition?

☐ Yes. Complete box C. ☐ No. Explain why not. _____

C. Dates of use	Dose and frequency

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other: _____

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date